Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ATLANTIS HEALTHCARE LP 6300 SAMUELL BLVD #112 DALLAS TX 75228	MFDR Tracking #: M4-05-0920-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICA FIRST INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule. TWCC Rule 133.307 (j)(2) says only the reason brought up by the carrier can be heard at MDR. SOAH decisions say if the carrier doesn't care to respond then they lose their opportunity to put in a reason. If no reason is put in by the carrier as to the denial the commission puts it as a 'F'. All Fee guidelines have been followed…"

Amount in Dispute: $2,046.81*****

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding CPT code 97010: Please note, per the Trailblazer Local Coverage Determination (LCD) – code 97010 is a bundled code and is considered an integral part of a therapeutic procedure. Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is always included in the allowance for another therapy service/procedure performed. Regarding the other therapy services, it appears the billing party failed to document the proper performance of those services. Provider Marvel C. Subia billed a number of these services. However, the S.O.A.P. notes indicate the services were performed by Hui Li, O.T.R. In such cases, to merit reimbursement, the Licensed Therapist must bill/her own services."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/03/2003 thru 03/30/2004	96004, 97110, G0283, 97750-FC, 97546-WH, 99373	N/A	$2,046.81	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

*****On 07/05/2006, the requestor submitted an updated Table of Disputed Services removing CPT Codes 97545-WH and 97546-WH for date of service 03/23/2004.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §102.4(d) sets out the procedures for Non-Division Communications.
3. 28 Tex. Admin. Code §102.5 sets out the procedures for General Rules for Written Communications to and from the Division.

Issues

1. Did the requestor provide to the Division a current, correct address and contact information pursuant to 28 Tex. Admin. Code §102.4(d) and/or 102.5?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division was unable to contact the requestor via telephone attempts, internet, and Yellow Page directory searches. All listed phone numbers are not in service or disconnected. The healthcare provider has not provided a current, correct address or contact information in accordance with 28 Tex. Admin. Code §102.4(d) and/or 102.5. The requestor no longer operates an active practice at the above address. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that reimbursement cannot be recommended. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.